ATTACHMENT # 14

Recipient Complaints and Grievance Form

OKLAHOMA HEALTH CARE AUTHORITY
RECIPIENT COMPLAINT/GRIEVANCE FORM

Any problem or complaint that you may have concerning the Soonercare program is important to us. If your Health Plan can not solve your problem or if you are do not like the answer that your Health Plan gives you, we are interested in hearing about it. Please complete the information below and send it to the address on this form. In order to help you, we may need to give your name to your doctor, your health plan or another agency.

Client Information:

Name:_____ _____
FIRST LAST CASE NUMBER

Mailing Address:_____
NUMBER STREET

_____
CITY STATE ZIP

Phone Number:(_____)_____ Social Security #: ___ ___ _____

Authorized Representative Information(if any)

Name:_____
FIRST LAST

Mailing Address:_____
NUMBER STREET

_____
CITY STAT3 ZIP

Phone Number:(_____)_____

I would Iike to make a complaint about the following individual or organization:

Name:_____

Location:_____
Number Street City State Zip

Phone Number:(_____)_____

Please tell us about your complaint in the space below. Be as specific as possible and whenever possible, give the date(s) that the event occurred.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

[If you need more space, use another sheet of paper]

Form continued on back

ATTACHMENT # 15

Provider/Physician Grievance Form

OKLAHOMA HEALTH CARE AUTHORITY
PROVIDER/PHYSICIAN GRIEVANCE FORM

In order to process your grievance request, **all** of the requested information must be supplied. Failure to provide all of the information will result in a slower response from the OHCA.

Provider Information:

Company Name (if any): _____ Provider ID #: _____
Individual Name (if any): _____ Federal Tax ID # ____

Mailing Address: _____
Number Street

_____
City State Zip Code

Phone Number: ( ) _____

Authorized Representative information (If any]:

Name: _____

Mailing Address: _____
Number Street

_____
City State Zip Code

Phone Number: ( ) _____

Please give a complete narrative explanation of the problem you have encountered. Include the names of OHCA personnel you have dealt with, and the dates that specific events occurred. Use additional paper if necessary. Attach copies of any documents you would like to be considered.

[If you need more space, use another sheet of paper]

_____
_____
_____
_____
_____

ATTACHMENT # 16

Grievance/Appeals Docket Notification

GARTH L. SPLINTER M.D., M.B.A.
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

TO: Division Personnel

FROM: Legal Division Docket Clerk

RE: Docket No. 95-__
Hearing Request of _____

DATE:

On __date__, the above referenced member of provider requested an appeal. (The program panel made a decision on __date__, and the member timely appealed the panel's decision on __date__.

A hearing has been scheduled on __date__ at _____ o'clock _.m. The hearing is scheduled before Administrative Law Judge _____ Any continuance of the hearing date must be requested in writing to the Administrative Law Judge.

GARTH L SPLINTER, M.D., M.B.A.
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH *CARE* AUTHORITY

TO: Division Clerk

FROM: Legal Division Docket Clerk

RE: Docket No. 95-__
Hearing Request of _____

DATE:

An appeal has been received by the Legal Division by the above referenced member.

In accordance with the Authority's policy, a program panel review has been scheduled for __date__, at _____ o'clock–.m. The panel is comprised of _____ (Medical Director's Unit), _____ (Division affected), and _____ (person designated by the Medical Director). The panel must complete the review and/or interview and render a decision by __date__. A copy of the panel's written decision should be delivered to the Legal Division for mailing to the member.

ATTACHMENT # 17

Notification of Grievance Hearing

(DATE)

Appellant's Name
Appellant's Address

Re: Docket No. 95-__
Hearing Request of _____

Desr (Appellant):

A hearing has been scheduled on __date__ at _____ o'clock _.m., in the above referenced appeal. The hearing is scheduled before Administrative Law Judge _____. The hearing will be held in the (location of the hearing). Any continuance of the hearing date must be requested in writing to the Administrative Law Judge.

Enclosed is a copy of the applicable Oklahoma Health Care Authority policy which pertains to your appeal. A copy of a summary of your grievance, including pertinent documents and a list of witnesses, will be sent to you when completed. If you have any questions, please feel free to call at 530-3217.

Sincerely,

Docket Clerk

enclosures

ATTACHMENT # 18

SMI/SED Application and Determination Procedures

Overview
SMI/SED Application & Determination Process

When it is believed that an Urban *SoonerCare* client might be Seriously Mentally Ill (SMI) or Seriously Emotionally Disturbed **(SED),** there are procedures that both the (referring) provider organization(or health plan) and the Oklahoma Health Care Authority (OHCA) must follow. as well as requisite forms that must be properly completed, in order to appropriately assess the client and process the related 'Disenrollment' Determination forms in a timely manner.

The responsibilities and obligations of the provider organization and of the OHCA are clearly defined in the subsequent pages of this ATTACHMENT.

The remainder of this ATTACHMENT is comprised of:

1. Attachment 18-A defines the responsibilities of the (referring) provider organization and references the applicable forms that must be completed;
2. Attachment 18-B defines the responsibilities of the OHCA as well as the timetable it must adhere to in processing a Disenrollment Request;
3. Attachment 18-C provides an introduction and overview of the Client Assessment Record (C.A.R.). The nine (9) scales and six (6) levels of functioning contained in the C.A.R. are designed to provide clinicians with a comprehensive overview of the client's capacity to adapt to the environment and survive in the community;
4. Attachment 18-D is the *SoonerCare SMI/SED Authorization Disposition Form* that must be completed by the (referring) clinician and submitted along with the appropriate (SMI or SED) *Determination Form*;
5. Attachment 18-E is the *Determination Form* that must be completed and submitted by the clinician if the client is a child (less than 21 years of age); and
6. Attachment 18-F is the *Determination Form* that must be completed and submitted by the clinician if the client is an adult (21 or more years of age).